U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 29 December 2006

CASE NO.: 2005-BLA-6258

In the Matter of
M.G.
Surviving Spouse of
J.G.,

Claimant

v.

ELKAY MINING COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Leonard J. Stayton, Esq.
For the Claimant

Kathy L. Snyder, Esq.
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS[1]

This proceeding arises from a request for modification, under 20 C.F.R. § 725.310, of a survivor's claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. ("Act"), originally filed on June 20, 1996. The modification request was filed on December 23, 2004.

The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 ("Regulations"), provide compensation and other benefits to:

[1] Sections 718.2 and 725.2 (c) address the applicability of the new regulations to pending claims.

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;

2. Surviving dependents of coal miners whose death was due to pneumoconiosis;[2] and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis"("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant, the surviving spouse of a deceased miner, filed a survivor's claim for black lung benefits on June 20, 1996. (Director's Exhibit (DX) 1). An initial finding of entitlement was made. The proposed Decision and Order, issued on November 1, 1996, found that the miner had pneumoconiosis, that it arose out of coal mine employment and that his death was due to pneumoconiosis and benefits were awarded. (DX 26). The employer contested the determination and requested a formal hearing. The case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs ("OWCP") for a formal hearing. An Administrative Law Judge ("ALJ") conducted a hearing and subsequently awarded survivor's benefits, on July 30, 1999. (DX 45). The Department of Labor Benefits Review Board ("Board" or "BRB") vacated the award, on November 2, 2000, and remanded, requiring the ALJ to make an "equivalency" determination (for complicated pneumoconiosis) as required by the Fourth Circuit's decision in *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999).

On remand, the same ALJ made the required determination finding that the medical pathology evidence met the "equivalent" of a one centimeter opacity on X-ray required to find complicated pneumoconiosis. (DX 55). The employer once again appealed and the BRB, on March 29, 2002, once again remanded. (DX 62). On June 28, 2002, the ALJ denied benefits on remand. (DX 63). The claimant, once again, appealed. (DX 64). The BRB affirmed the denial, on July 31, 2004. (DX 74). On September 9, 2003, the Claimant appealed to the U.S. Court of Appeals for the Fourth Circuit. (DX 95). On April 8, 2004, the Fourth Circuit affirmed the denial of benefits, per curiam. (DX 77). The U.S. Supreme Court denied the claimant's Petition for Writ of Certiorari, on July 6, 2004.

The claimant then filed the present request for modification, on December 23, 2004. (DX 78). The District Director denied the request stating no decision would be ordered and the case was transferred to the Office of Administrative Law Judges.

[2] Claims filed on or after Jan. 1, 1982 (with an exception for survivors of miners who died on or before Mar. 1, 1978 (20 C.F.R. § 718.306)). 20 C.F.R. § 718.1. This applies here.

The case was assigned to me on February 17, 2006. On July 12, 2006, I held a hearing in Charleston, West Virginia, at which the claimant and employer were represented by counsel.[3] No appearance was entered for the Director, OWCP. The parties were afforded the full opportunity to present evidence and argument. Director's exhibits ("DX") 1- 100, Claimant's exhibits ("CX") 1-4, and Employer's exhibits ("EX") 1-11, were admitted into the record.[4]

I extended the closing of the record until September 25, 2006, in order to receive closing briefs.

ISSUES

I. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner's death was due to pneumoconiosis?

IV. Whether a mistake of fact had been made in the prior denial?

FINDINGS OF FACT

I. Background

Having reviewed and considered the supporting evidence, I adopt Judge Leland's factual findings, set forth in his Decision and Order on Remand Denying Benefits, June 28, 2002, (1997-BLA-0891) except to the extent contrary findings are made herein.[5] The ALJ had found that the opinions of Drs. Naeye and Kleinerman were not sufficient to establish invocation of the irrebuttable presumption of death due to pneumoconiosis, under Section 718.304, as neither doctor's opinion supported the requisite "equivalency determination" required by *Blankenship*. Specifically, the Judge found that Dr. Naeye's deposition testimony that a twelve millimeter nodule viewed on the miner's 1990 lobectomy and two centimeter lesions viewed on autopsy slides would "look like complicated pneumoconiosis on x-ray" "falls short of a specific finding that these lesions would be seen as at least one centimeter opacities on x-ray." He further found Dr. Kleinerman's opinion and testimony not supportive of an equivalency finding, as he never indicated that there were lesions viewed on autopsy that would be seen as at least one centimeter opacities on x-ray.[6] Moreover, in affirming the ALJ's findings, the BRB held that the ALJ had correctly determined that the opinions of the other pathologists of record (Drs. Hansbarger,

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[3] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.

[4] DX 88-100 concern procedural development of the case.

[5] Those findings were affirmed by the BRB. The BRB's Decision and Order was affirmed by the U.S. Court of Appeals for the Fourth Circuit.

[6] In his deposition, Dr. Kleinerman discussed a 1.5 centimeter nodule which he identified on a 1992 x-ray and characterized as a tumor.

Green, and Perper and others) had also failed to support an equivalency determination and invocation of the section 718.304 presumption.[7]

In his April 19, 1995 report, Dr. Naeye indicated that, with regard to the 1990 lobectomy, masses of carcinoma engulfed anthracotic micro and macronodules, and that in combination, some of these masses might have been large enough on gross examination and x-ray, to appear to be complicated pneumoconiosis. He indicated that the masses were not complicated pneumoconiosis, but a combination of simple pneumoconiosis and carcinoma. Similarly, in his 1988 deposition, Dr. Naeye testified that, with respect to the autopsy slides, the two centimeter lesions found on autopsy was comprised of micro and macronodules which joined together, and which indicated a disease process different from features associated with complicated pneumoconiosis, namely simple pneumoconiosis and carcinoma.

A. Survivorship

The Claimant and her now deceased husband were married at the time of the miner's death and she has not remarried since. (DX 1). I find the claimant is an eligible survivor of a miner.

B. Coal Miner

It is not contested and I find the claimant's now deceased husband was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for at least thirty-four years and five months. (DX 45).

C. Date of Filing[8]

The claimant filed her modification request, under the Act, on December 23, 2004. (DX 1). The matter was not contested and I find none of the Act's filing time limitations are applicable; thus, the claim was timely filed.

D. Responsible Operator

Elkay Mining Company was the last employer for whom the claimant worked a cumulative period of at least one year and agreed it is the properly designated responsible coal mine operator in this case, under Part 725 of the Regulations.[9]

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[7] This would apply to Dr. Perper's 64-page review and opinion, dated May 23, 1999, submitted in connection with the earlier claim and presently submitted as DX 80. Drs. Hansbarger, Green, and Perper had all found CWP nodules greater than 2 cm on autopsy. Dr. Dy had also diagnosed complicated CWP.

[8] 20 C.F.R. § 725.308 (Black Lung Benefits Act as amended, 30 U.S.C.A. §§ 901-945, § 422(f)).
(a) . . . There is no time limit on the filing of a claim by the survivor of a miner.
20 C.F.R. §725.310 (For Modifications) provides:
(a) . . .the district director may, at any time before one year from the date of the last payment of benefits, or at any time before one year after the denial of a claim, reconsider the terms of an award or denial of benefits.

[9] 20 C.F.R. § 725.492. The terms "operator" and "responsible operator"are defined in 20 C.F.R.§ § 725.491 and 725.492. The regulations provide two rebuttable presumptions to support a finding the employer is liable for benefits: (1) a presumption that the miner was regularly and continuously exposed to coal dust; and (2) a presumption that the miner's pneumoconiosis **(disability or death and not pneumoconiosis for claims filed on or after Jan. 19, 2001)** arose out of his employment with the operator. 20 C.F.R. §§ 725.492(c) and 725.493(a)(6) (§§ 725.491(d) and 725.494(a) for claims filed on or after Jan. 19, 2001). To rebut

E. Dependents

The miner had only his wife as a dependent for purposes of augmentation of benefits under the Act, until his death. (DX 1).

F. Personal, Employment, and Smoking History

The decedent miner was born on April 10, 1924. He worked, underground, in the coal mines for over thirty-four years. He last worked in the coal mines in 1984. He stopped working then, at age sixty. The miner died at age 82, on June 8, 1996. (DX 1). He had breathing problems and was on oxygen prior to his death and was being treated for lung cancer at the time of his death. He smoked approximately one half pack of cigarettes a day from 1942 until 1984 when he had open heart surgery.

II. Medical Evidence

A. Chest X-rays[10]

Chest X-rays from the miner's first claim, filed June 30, 1973, did not reveal any large opacities, but an August 18, 1990 X-ray from the miner's July 31, 1990 claim was read as showing large opacities by Drs. Gaziano, Wiot, Spitz, Shipley, and Wheeler. The latter four believed the mass in the upper left lung lobe may represent a carcinoma. They interpreted the miner's May 14, 1991 X-ray, taken after a portion of his cancerous left lung was removed, on October 27, 1990, as negative for any large opacities. The other radiologists reading that X-ray shared this view. Later X-rays showed only simple CWP. All the post-lobectomy X-rays and CTs, taken between 1991 and 1994, failed to reveal the existence of large opacities. Drs. Wheeler and Scott concluded the CT scans of May 7, 1993 and February 22, 1994 were negative for large opacities. No X-ray readings were presented in the original survivor's claim.

There were 58 readings of 28 X-rays taken between March 1, 1979 and May 25, 1994. Thirty-two of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b). Twenty-seven of the properly classified readings are positive for pneumoconiosis.[11] None of the properly classified readings are negative. Four readings were "unreadable" (u/r) by Dr. Wiot. Dr. Wiot is responsible for fifteen positive readings. The majority of the properly

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the fist, the employer must establish that there were *no* significant periods of coal dust exposure. *Conley v. Roberts and Schaefer Coal Co.*, 7 B.L.R. 1-309 (1984); *Richard v. C & K Coal Co.*, 7 B.L.R. 1-372 (1984); *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). To rebut the second, the operator must prove "within reasonable medical certainty or at least probability by means of fact and/or expert opinion based thereon that the claimant's exposure to coal dust in his operation, at whatever level, did not result in, or contribute to, the disease." *Zamski v. Consolidation Coal Co.*, 2 B.L.R. 1-1005 (1980). Neither presumption has been rebutted in this case.

[10] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[11] According to the American Thoracic Society (ATS):
In interstitial diseases with small rounded or irregular opacities, such as coal workers' pneumoconiosis or asbestosis, respectively, the correlation between physiologic and radiographic abnormalities is poor. The only exception is when there is radiographic evidence of progressive massive fibrosis (PMF). As the PMF intensifies, there is frequently a significant reduction in the ventilatory capacity.

classified readings are by physicians who are A-readers, B-readers, board-certified radiologists, or both.[12] Appendix A, the table of readings, sets out the details.

B. CT Scans

Dr. Cordell interpreted a CT, dated 10/11/90, as showing a mass in the upper left lobe consistent with a neoplasm and suspicious for metastasis. (DX 2). On a May 7, 1993, CT he found multiple metastatic lesions with two rounded nodules LUL decreasing and enlarged nodes in cornua consistent with metastatic disease. (DX 37). Dr. Wiot read the same CT as "2/1, q/t, ca." (DX 2). Dr. Wheeler reported "small round nodules in central lung which could be silicosis or CWP" on the same CT. (DX 2). Dr. Scott reported the May 7, 1993, CT was "negative." (DX 2). A February 22, 1994 CT had five readings. Drs. Wheeler and Scott found it "negative." (DX 2). Dr. Willis reported that it reflected multiple pulmonary parenchymal nodules and increasing size of multiple masses consistent with increasing metastatic disease. Dr. Wiot reported it as " 2/1, q/t, ca, od." (DX 2).

C. Pulmonary Function Studies [13]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Qualify***	**Conform****
Caronel 3/1/79 DX 1	54 69"	2.81	116		Yes	NQ	Yes
Ranavaya 8/18/90 DX 2	66 69"	2.13	95.6	3.15	Yes	NQ	Yes

[12] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. §37.51. Courts generally give greater weight to x-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993)

[13] § 718.103 (a)(Effective for tests conducted after Jan. 19, 2001(see 718.101(b))), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician Date Exh.#	Age Height	FEV_1	MVV	FVC	Tra-cings	Qualify*	Conform**
Zaldivar 8/29/90 DX 2	66 67”	2.17 2.42	104 117	3.31 3.46	Yes	NQ NQ+	Yes
Crisalli 5/14/91 DX 2	67 67”	2.14	91	3.60	Yes	NQ	Yes
Kayi 3/10/92 DX 2	67 68”	1.85 1.98	67 68	3.35 3.05	Yes	NQ NQ+	Yes
Crisalli 2/15/95 DX2	70 67"	1.55 1.75	57	2.82 3.00	Yes	NQ NQ+	Yes

* A "qualifying" pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.
** A study "conforms" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (see *Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)).
Appendix B (Effective Jan. 19, 2001) states: "(2) The administration of pulmonary function tests shall conform to the following criteria:
(i) Tests shall not be performed during or soon after an acute respiratory illness. . ."
Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).
+Post-bronchodilator.

For a miner of the height of 67” inches (his most recently-reported height), ' 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.68 for a male 70 years of age. If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.18 an MVV equal to or less than 67 or a ratio equal to or less than 55% when the results of the FEV_1 test are divided by the results of the FVC test.[14]

[14] According to the American Thoracic Society (ATS) “For interstitial lung disease, the FVC has proved to be a reliable and valid index of significant impairment.” Guidelines to the Evaluation of Permanent Impairment, AMA 3rd Edition (Revised 1990) at 119.

D. Arterial Blood Gas Studies[15]

Blood gas studies are performed to detect an impairment in the process of aveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

Date Ex.#	Physician	pCO2	pO2	Qualify
3/1/79 DX 1	Carbonel	29	82	NQ
8/18/90 DX 2	Ranavaya	38	78	NQ
5/14/91 DX 2	Crisalli	39	80	NQ
3/10/92 DX 2	Kayi	42.4	62.9	NQ
4/19/94 DX2	CAMC	33	74	NQ
2/15/95 DX2	Crisalli	37	86	NQ

A lower level of oxygen (O2) compared to carbon dioxide in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

* Results, if any, after exercise.
Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

E. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4).

In the earlier claim, Dr. Khan, the surgeon who performed the miner's upper left lung lobectomy, on October 27, 1990, opined his lungs showed typical changes of complicated CWP. Dr. Klapproth found progressive massive fibrosis in the pathology report associated with the procedure. The pathology report further diagnosed adenocarcinoma. But, the majority of

[15] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: ...
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part...

pathologists, who reviewed the histologic slides, diagnosed only simple CWP.[16] Dr. Naeye found only severe simple pneumoconiosis. Drs. Kleinerman and Hansbarger declined to diagnose complicated CWP, because the lesions they observed were less than 2 cm. Dr. Mohammed Ranavaya reviewed the medical evidence diagnosed complicated CWP and opined that the miner had CWP arising from coal mine dust exposure and that it was a substantially contributing cause or factor leading to the miner's death. (DX 24). The employer's pathologists, Drs. Bush and Hutchins did not suffer from complicated CWP and that any CWP he may have had did not contribute to his death. The claimant's pathologists, Drs. Perper and Green, found otherwise, as noted below.

In the earlier claim, Dr. Chillag and the employer's expert pulmonologists, Drs. Loudon, Fino, Stewart, and Zaldivar, all concluded the decedent did not suffer from complicated CWP and that any CWP which may have been present did not contribute to his death. Drs. Loudon, Chillag, Fino, Stewart, and Zaldivar, all concluded the miner suffered from simple CWP.

Dr. Perper submitted a supplemental medical report, dated February 3, 2005. (DX 81; CX 2). Dr. Perper is a pathologist currently serving as a clinical professor of pathology, University of Miami, School of Medicine. His CV reflects extensive research and writing in his field. In his original report, May 23, 1999, Dr. Perper had diagnosed progressive massive fibrosis and severe centrilobular emphysema caused by exposure to coal dust. He opined the miner died from a number of concurrent causes including severe CWP with progressive massive fibrosis, severe chronic pulmonary disease with severe centrilobular emphysema, ischemic heart disease with old myocardial infarction and terminal bronchopneumonia. The CWP substantially contributed to death directly and indirectly through hypoxemia associated with the progressive massive fibrosis on a background of severe simple CWP and simple nodular silicosis, associated centrilobular emphysema and the complications of adenocarcinoma of the lungs. He added that even if the miner did not have complicated CWP and his lung cancer and centrilobular emphysema were not caused by exposure to coal dust, it would be unreasonable to claim the miner's severe CWP did not play a role in his death.

In the supplemental report, Dr. Perper concluded that the pathological-diagnosed lesions of coal workers' pneumoconiosis found at autopsy are diagnostic of complicated pneumoconiosis and "equivalent to nodular radiological lesions of more than 1.0 cm." (DX 81). He observed the autopsy's gross description included at least two nodular areas of black fibro-anthracosis, measuring 7.25 by 3.0 cm and 5.5 by 5 by 5.3 cm respectively. Microscopically, the lung tissue was described as showing dense scarring of massive progressive fibrosis. He had found microscopically, that the histologic slides showed lesions of complicated pneumoconiosis measuring "up to 2.3 by 2.3 cm." (DX 81). He reported that lesions of 2.0 cm or greater are equivalent to radiological-observed nodules of more than 1.0 cm. (DX 81). Moreover, Dr. Perper had conducted an experiment evaluating the relationship between the actual size of a lesion and its appearance on x-ray. That illustrated that the appearance on x-ray is dependent on the source of the x-rays, the film and the location of the body. As a result, he concluded that "any pathologic lesion found at the autopsy cannot appear on the chest x-ray film as smaller than its

[16] The biopsy slides reviewed by the pathologists in the miner's claim were from the left lung, but the large lesion from the autopsy slides was from the miner's right lung.

actual size, but must be the same size or larger than its actual size. Conversely a radiological nodule may be in actuality: equal, larger, or smaller that (sic) its true size, depending on its relative location in the body, and distance from the radiological film." (DX 81). Therefore, given the size of the lesions he found, he had no doubt that they would equate radiographically shown opacities diagnostic of complicated CWP. (CX 2).

Dr. Green submitted a supplemental medical report, dated June 10, 2005. (CX 1). Dr. Green is Board-certified in Anatomic Pathology and currently a pathology professor at the University of Calgary and a member of the task group revising regulations for the National Coal Workers' Autopsy Program. He had previously found nodules slightly larger than two centimeters and had diagnosed progressive massive fibrosis and severe simple macular, nodular and silicotic CWP, cor pulmonale and adenocarcinoma, in his March 19,1999 report. He now notes that those lesions would appear as larger than those measurements on X-ray. Noting the miner's 1990 lung resection due to lung cancer, he had opined the miner died from complications of lung cancer in combination with pneumoconiosis. In 2005, he added that the one centimeter lesions shown in his histologic slide review would appear as an image on X-ray slightly larger than one centimeter. (CX 1). He concluded that any lesion on the slides of one centimeter or greater would always meet the radiographic criteria for progressive massive fibrosis. He attached a report of Dr. Gregory R. Wagner, NIOSH Director, Division of Respiratory Disease Studies, in support of his opinion. Dr. Green reported that NIOSH uses a one centimeter pathology standard in diagnosing complicated CWP. He reiterated his earlier conclusions that the miner died as a result of complications of his lung cancer and CWP which caused severe pulmonary impairment. (CX 1).

The employer submitted a supplemental medical report, dated February 7, 2006, and a June 14, 2006 deposition of eminently-qualified Dr. Richard L. Naeye. (EX 1; EX 10). Dr. Naeye had previously submitted medical reports and deposition testimony, between 1995 and 1999. He reiterated his earlier assessment that the pathologic slides show the existence of simple pneumoconiosis, but not complicated pneumoconiosis. (EX 1). He explained that many medical studies have established that coal mine dust exposure does not cause cancer, as opined by Dr. Perper.[17] He testified that unlike Drs. Perper and Green, he believed the fibrous changes observed in the miner's lung tissue and lesions were partially due to coal dust exposure, but also due to the immunologic or desmoplastic reaction of lung cancer. (EX 10 at 11-12). He explained those lesions did not have the characteristics of complicated CWP. (EX 10 at 19). He explained the three factors requisite for a complicated CWP diagnosis were absent from the histologic slides in the present case. He explained that medical authorities do not suggest there is solely a size standard for the diagnosis of complicated CWP by pathology. And disagreed with Dr. Perper's assertion it could.[18] (EX 10 at 14). Dr. Naeye found no large opacities of CWP in the miner's lungs. He opined that an X-ray film can give the impression of a much larger lesion than one found on pathology, in part because lesions are often superimposed. This miner's lesions, in excess of one centimeter, were due to a combination of coal dust exposure, cancer and radiation. (EX 10 at 18).

[17] Likewise, Dr. Bush found Dr. Perper's assertion that lung cancer may be caused by coal mine dust exposure incorrect.
[18] J. Kleinerman, *et al,* Archives of Pathology and Laboratory Medicine, Special Issue, June 1979, "Pathologic Standards for Diagnosis of Coal Workers' Pneumoconiosis."

The employer submitted a supplemental medical report, dated February 16, 2006, and a June 14, 2006 deposition of Dr. Stephen T. Bush. (EX 3; EX 11). He is Board-certified in anatomic and clinical pathology. Dr. Bush had previously authored reports, dated December 24, 1997 and June 16, 1999. (DX 37). He had originally diagnosed simple CWP, but not complicated CWP. He faulted Drs. Perper and Green for not considering the composition of the lesions, they called complicated CWP, which were exaggerated in size by the growth of the carcinoma and its associated fibrosis stonma (within the lesion) but are not complicated CWP. (EX 3 at 1). He did not see the 2.3 by 2.3 cm CWP lesion discussed by Dr. Perper. (EX 11 at 38-39). Dr. Bush believes only the part of the lesion which is CWP may be used to address the existence of PMF and the severity of the disease. He specifically disagreed with Drs. Perper and Green on this point. He disagreed with Dr. Green's view that tissues on histologic slides will shrink at a rate of 15% during processing. Rather, shrinkage is minimal because the dense tissue reduces shrinkage. He found places in the lungs where the fibrous scarring from cancer and coal dust where adjacent or merged. He found Dr. Green's cor pulmonale diagnosis presumptuous absent further evaluation and disagreed with the finding. (EX 11 at 35-36).

The employer submitted a supplemental medical report, dated February 8, 2006, and a June 14, 2006 deposition of Dr. Grover M. Hutchins. (EX 2). Dr. Hutchins had previously authored reports, dated November 22, 1997 and June 22, 1999. (DX 37). He had originally diagnosed simple CWP, but not complicated CWP. (EX 2). He reaffirmed that opinion in his supplemental medical report. (EX 2). Dr. Hutchins criticized Dr. Perper's experiment and conclusions regarding the size of pathologic specimens seen on X-ray. He observed "the degree of magnification of a radiologically detectable lesion. . . is negligible [since] standard chest radiographs are taken with a distance between the focal spot of the x-ray tube and the radiographic film of 72 inches." (EX 2). He likewise criticized Dr. Green's opinion, observing that the standard chest radiograph is taken posterior-anterior ("PA") not anterior-posterior ("AP"), "so any magnification effect would be more pronounced on posterior lesions, not those in the anterior chest." (EX 2). He agreed with Drs. Naeye and Bush that no large opacities of CWP existed in the miner's lungs.

Dr. Gregory Fino, who is board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed claimant's medical records on behalf of the employer and submitted his opinions in a supplemental report, dated May 25, 2006 . (EX 5). Dr. Fino had previously authored reports, in 1991, 1995, and 1998. (DX 2, 37). He had originally diagnosed simple CWP, but not complicated CWP. He reaffirmed that opinion in his supplemental medical report stating that nothing in the supplemental reports of Drs. Perper or Green changed his opinion that the objective studies, pathology evidence, and radiological evidence do not establish complicated CWP. (EX 5).

Dr. Bruce N. Stewart, who is board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed claimant's medical records on behalf of the employer and submitted his opinions in a supplemental report, dated May 25, 2006 . (EX 7). Dr. Stewart had previously authored reports, in 1992, 1995, and 1998. (DX 37). He had originally diagnosed simple CWP, but not complicated CWP. He reaffirmed that opinion in his supplemental medical report stating that nothing in the supplemental reports of Drs. Perper or

Green changed his opinion that the objective studies, pathology evidence, and radiological evidence do not establish complicated CWP. (EX 7).

Dr. Robert J. Crisalli, who is board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed claimant's medical records on behalf of the employer and submitted his opinions in a supplemental report, dated May 25, 2006. (EX 9). Dr. Crisalli had previously authored reports, in 1991,1995, 1999. (DX 2, 37). He had originally diagnosed simple CWP, but not complicated CWP. He reaffirmed that opinion in his supplemental medical report stating that nothing in the supplemental reports of Drs. Perper or Green changed his opinion that the objective studies, pathology evidence, and radiological evidence do not establish complicated CWP. (EX 9).

F. Death Certificate

The death certificate lists the date of death as June 8, 1996. The cause of death was listed by Dr. Bae as cardiac respiratory arrest, lung cancer, and arteriosclerotic heart disease and other significant conditions contributing to death but not resulting in the underlying cause "chronic obstructive lung disease and coal workers' pneumoconiosis." (DX 2).

G. Autopsy

Dr. Antonio Dy performed an autopsy on June 10, 1996, which included both a gross and microscopic examination. (DX 25). He diagnosed an area of "solid blackish anthracosis of progressive massive fibrosis" of complicated CWP measuring 5.5 by 5.0 by 3 cm in the upper lobe of the right lung on gross examination. He observed two large areas of grayish-white masses with stellate margins and surrounding anthracosis from the middle and lower lobes of the right lung measuring 7 cm by 5 cm by 3 cm and 3.0 cm by 2.5 cm by 2.5 cm. He also observed extensive infiltration of the adenocarcinoma. Although he did not explicitly correlate specific microscopic findings to the specifically-mentioned lesions, he concluded the miner had massive progressive fibrosis (advanced or complicated anthracotic pneumoconiosis), both lungs.

His final anatomical diagnosis included: (1) early acute bronchopneumonia dependent portions, lower lobes, both lungs; (2) massive progressive fibrosis (advanced or complicated anthracotic pneumoconiosis), both lungs; (3) extensive infiltrating well differentiated adenocarcinoma with metastases to hilar and surrounding regional lymph nodes, both lungs; (4) visceral pleural fibrosis with circular anthracosis;(5) extensive confluent nodular hyalinizations, hilar and surrounding regional lymph nodes; (6) status post sternotomy and wiring of the sternum.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

Part 718 applies to survivors' claims which are filed on or after April 1, 1980. 20 C.F.R. § 718.1. There are four possible methods of analyzing evidence in a survivor's claim under Part 718: (1) where the survivor's claim is filed prior to January 1, 1982 and the miner is entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (2) the survivor's claim is filed prior to January 1, 1982 and there is no living miner's claim or the miner is not found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; (3) the survivor's claim is filed after January 1, 1982 and the miner was found entitled to benefits as the result of a living miner's claim filed prior to January 1, 1982; and, (4) the survivor's claim is filed on or after January 1, 1982 where there is no living miner's claim filed prior to January 1, 1982 or the miner is found not entitled to benefits as a result of a living miner's claim filed prior to January 1, 1982. The fourth, Subsection 718.205(c) applies to this claim.[19]

The Part 718 regulations provide that a survivor is entitled to benefits only where the miner died due to pneumoconiosis. 20 C.F.R. § 718.205(a). As a result, the survivor of a miner who was totally disabled due to pneumoconiosis at the time of death, but died due to an unrelated cause, is not entitled to benefits. 20 C.F.R. § 718.205(c). Under § 718.205(c)(4)(2001), if the principal cause of death is a traumatic injury or a medical condition unrelated to pneumoconiosis, the survivor is not entitled to benefits unless the evidence establishes that pneumoconiosis was a substantially contributing cause of the death.

The Regulations now provide and the Board has held that in a Part 718 survivor's claim, the Judge must make a threshold determination as to the existence of pneumoconiosis arising out of coal mine employment, under 20 C.F.R. § 718.202(a), prior to considering whether the miner's death was due to the disease under § 718.205. 20 C.F.R. § 718.205(a); *Trumbo v. Reading Anthracite Co*., 17 B.L.R. 1-85 (1993). Then, it must be established the pneumoconiosis arose out of coal mine employment and that the miner's death was due to pneumoconiosis. *See, Haduck vs. Director, OWCP*, 14 B.L.R. 1-29 (1990) and *Boyd v. Director, OWCP*, 11 B.L.R. 1-39 (1988).

B. Existence of Pneumoconiosis

All the physicians providing opinions in this matter have opined the miner at least suffered from simple coal workers' pneumoconiosis caused by his lengthy coal mine dust exposure. As counsel point out, the pertinent issue, in this claim, is whether the miner had complicated pneumoconiosis which would raise the irrebuttable presumption, 20 C.F.R. § 718.304, or whether he had simple CWP which contributed to his death.

[19] The survivor is not entitled to the use of lay evidence, or the presumptions at §§ 718.303 and 718.305 to aid in establishing entitlement to survivors' benefits. Third Circuit, *Contra*, *Soubik v. Director, OWCP*, ___ F.3d ___, Case No. 03-1668 (3rd Cir. April 30, 2004).

30 U.S.C. § 902(b) and 20 C.F.R. §718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.[20] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[21] 20 C.F.R. §718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

"...[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co.*, 914 F.2d 35 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co*., 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, bronchitis, asthmatic bronchitis, bronchial asthma or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 BLR 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co*., 6 BLR 1-666 (1983)(bronchitis secondary to coal dust within definition). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. See § 718.201(a)(2); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995) and *Youghiogheny & Ohio Coal Co. v. McAngues*, 996 F. 2d 130, 133 (6th Cir. 1993) (COPD).

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[20] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 314-315 (3d Cir. 1995) .

[21] Regulatory amendments, effective January 19, 2001, state:

For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R.§' 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106;[22] (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[23] 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. Burke v. Director, OWCP, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 303 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R.§ 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The parties do not dispute that the deceased miner suffered from simple coal workers' pneumoconiosis at the time of his death. The vast majority of X-ray readings are positive for at least simple CWP and nearly all physicians agree the miner suffered from CWP. The heart of this case, is whether the miner suffered from complicated pneumoconiosis. That determination rests on a finding relating to the opacities found on one X-ray examination of August 18, 1990 and the pathology reports. Four of seven readers found category "A" or "B" opacities on that film; Drs. Wiot, Spitz, Shipley, and Gaziano. The former three are dually-qualified readers. Dr. Gaziano, who read the same x-ray three various times, is merely a B-reader. Of the three remaining readers, Drs. Cole, Wheeler, and Scott, all dually-qualified, none found complicated CWP, but all three found simple CWP and lung cancer.

Under 20 C.F.R § 718.304, there is an irrebuttable presumption that a miner's death was due to pneumoconiosis or that the miner was totally disabled due to pneumoconiosis at the time of his death if he suffered from complicated pneumoconiosis. "Legal" complicated pneumoconiosis may be established if (a) an x-ray of the miner's lungs shows an opacity greater than one centimeter in diameter; (b) a biopsy or autopsy shows massive lesions in the lungs; or (c) when diagnosed by other means, the condition could reasonably be expected to reveal a result equivalent to (a) or (b). See § 718.304. The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh

[22] A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis, but positive results will constitute evidence of the presence of pneumoconiosis 20 C.F.R. § 718.106(c)

[23] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

all relevant evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co*., 7 B.L.R. 10683 (1985). To that end, the administrative law judge must consider all evidence on the issue, i.e., evidence of simple and complicated pneumoconiosis, as well as evidence of no pneumoconiosis, resolve the conflicts, and make a finding of fact. *Cornelius v. Pittsburg & Midway Coal Mining Co*., BRB No. 04-0162 BLA (Sept. 30, 2004)(unpub.).

Additionally, recognizing that the Regulations set forth three means for establishing complicated pneumoconiosis, the Fourth Circuit requires the Administrative Law Judge to make an "equivalency determination" to ascertain whether the miner had the prescribed condition regardless of the diagnostic means presented. See *E. Assoc. Coal Corp. v. Director*, *OWCP* [*Scarbro*], 220 F.3d 250 (4th Cir. 2000); *Double B Mining Inc. v. Blankenship*, 177 F.3d 240 (4th Cir. 1999). To that end, the Fourth Circuit found that "'because prong (A) sets out an entirely objective scientific standard'- i.e. an opacity on an X-ray greater than one centimeter- X-ray evidence provides the benchmark for determining what under prong (B) is a 'massive lesion' and what under prong (C) is an equivalent result reached by other means." Scarbro, 220 F. 3d at 256(citing *Double B*, 177 F.3d at 243). With respect to autopsy evidence, it requires that the miner have "massive lesions," which are lesions that would show on an X-ray as opacities of at least one centimeter. See *Double B*, 177 F.3d at 244. [24]

In *Double B*, the Court held that the administrative law judge, in finding that a physician's diagnosis, on biopsy, of "pneumoconiosis with massive fibrosis" satisfied the "massive lesions" requirement entitling the claimant to the irrebuttable presumption of total disability due to pneumoconiosis provided at 20 C.F.R. § 718.304(b), failed to make the "equivalency determination" required by section 921(c)(3) of the Act. It required the judge to determine whether the 1.3 cm nodule diagnosed on biopsy would, if x-rayed prior to removal of that portion of the miner's lung, have shown a greater than one centimeter opacity on x-ray, as required by section 411(c)(3)(A) of the Act, 30 U.S.C. § 921(c)(3)(A) and the promulgating regulation at 20 C.F.R. § 718.304(a). The Court declined to impose a rule that a lesion or nodule diagnosed by biopsy or autopsy must be 2 cm or larger in diameter in order to equate to a greater than one centimeter opacity on x-ray. "Massive lesions" are those that when x-rayed show opacities of greater than one centimeter in diameter. (The Court later wrote the opacity must be "at least" one cm.)

In *Scarbro*, the Court affirmed the judge's finding that the x-ray and autopsy evidence supported invocation of the presumption at 20 C.F.R. § 718.304 (complicated pneumoconiosis). Prongs (A), (B), and (C), under § 718.304 are written in the disjunctive such that a finding of complicated pneumoconiosis may be established based upon evidence presented under one of the prongs "[b]ut the ALJ must in every case review the evidence under each prong of § 921(c)(3) for which relevant evidence is presented to determine whether complicated pneumoconiosis is present." Complicated pneumoconiosis is established through application of "congressionally defined criteria" and the most objective measure of the condition is obtained through chest x-rays. Thus, the Court rejected the employer's argument that the x-ray findings of complicated

[24] Here, the Fourth Circuit mandated as much with respect to biopsy evidence. However, because autopsy and biopsy evidence are both part of prong (B) of the standard, the ruling applies to autopsy evidence as well.

pneumoconiosis were contradicted by the autopsy evidence. The congressionally-defined statutory definition of complicated pneumoconiosis "betrays no intent to incorporate a purely medical definition." [25] (Emphasis added). As a result, a pathologist's finding that a 1.7 cm nodule did not constitute complicated pneumoconiosis in the medical sense was insufficient to exclude its presence in the legal sense.

In *Clinchfield Coal Co. v. Fultz*, Case No. 02-1107, 2003 WL 1735260 (4th Cir. April 2, 2003)(Unpub.) the Court clarified its holding in *Scarbro*, by stating it "did not find that autopsy evidence of lesions of 1.7 cm supported invocation of the irrebuttable presumption" of complicated CWP; rather, the Court "held that where doctors read the x-ray evidence as showing lesions greater than one centimeter in diameter, autopsy evidence of lesions 1.7 cm did not undermine the x-ray evidence." The court noted that there might be lesions so large that it is self-evident they would be over 1 cm on x-ray, that was not the case with the 1.2 cm lesion here. Moreover, here there was no evidence that the 1.2 cm lesion on autopsy would have equated to one over 1 cm on x-ray. Thus, the presumption was appropriately not applied.

In *Williams v. Ray Todd Coal Co*., BRB No. 04-0388 (Dec. 23, 2004)(Unpub.), the BRB rejected the contention that judges may not consider medical opinions and objective tests detecting no disabling impairment in determining whether a claimant has established invocation of the irrebuttable presumption, under Section 718.304 (total disability due to complicated pneumoconiosis). Other evidence may show that X-ray opacities may not be what they appear to be. *Scarbro*, 220 F.3d at 256. The Fourth Circuit has explained that because Section 921(c)(3) provides an irrebuttable presumption only if "a chronic disease of the lung" is established, the totality of the evidence must be considered *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46 (4th Cir. 1993).

The pathological evidence of complicated CWP begins with Dr. Kahn, the surgeon who performed the miner's thoracotomy with left upper lung lobectomy in October 1990 (six years before his death) because of the neoplastic or cancerous process observed there. He observed the lungs showed typical changes of complicated CWP. Pathologist Klapproth found progressive massive fibrosis in the pathology report associated with the lobectomy. It was not determined whether the Category "A" or "B" opacity seen on the August 18, 1990 X-ray was removed during the surgical procedure performed by Dr. Kahn. Metastasized lung cancer again became suspect in 1994 according to Dr. Juberliner. (DX 37). After the miner's death, in 1996, the autopsy prosector, Dr. Dy, found progressive massive fibrosis in both lungs with an area of 5.5 by 5.0 by 3.0 centimeters. So, it was no surprise that, in 1999, the hearing judge awarded benefits. Yet, Drs. Kahn, Klapproth, and Dy, did not make the Court-imposed required "equivalency" determinations. Seven pathologists Perper, Green, Bush, Hutchins, Harnsbarger, Naeye and Kleinerman, all reviewed the autopsy and examined histologic slides. As noted in greater detail above, Drs. Perper and Green, on behalf of the claimant, have made "equivalency" determinations.

[25] The Court observed that, "Section 921(c)(3), which creates the irrebuttable presumption of causation, does not refer to the triggering condition as 'complicated pneumoconiosis,' nor does it refer to a medical condition that doctors independently have called complicated pneumoconiosis. Rather, the presumption under Section 921(c)(3) is triggered by a congressionally defined condition, for which the statute gives no name but which, if found to be present, creates an the irrebuttable presumption that disability or death was caused by pneumoconiosis." *Scarbro*, 220 F.3d at 257.

Dr. Perper, not only conducted his own experiment concerning "equivalency", but determined the pathological samples he saw, of 2.3 cm by 2.3 cm, would appear to be one or more centimeters in size on X-ray. Pathologist Bush reported he did not observe similar sized pathologic lesions.[26] Employer's pathologist Hutchins criticized Dr. Perper's radiological experiment. Unlike Dr. Perper, the latter pathologist discussed the mode of taking ILO X-rays which would impact the size of an opacity seen on X-ray. Dr. Hutchins commented that the degree of magnification of a radiologically detectable lesion is negligible. However, given that Appendix A requires a distance of six feet from the source or focal spot to the film, it is more likely that Dr. Perper is correct; that is that the opacities would appear larger than the actual lesions. Pathologist, Dr. Green likewise observed pathological nodules on slides over 2.0 cm which he reported would appear slightly greater than one centimeter on X-ray. In his June 10, 2005 report, Dr. Green noted that in his March 19, 1999 report, he had previously described two lesions, one measuring slightly more than two centimeters and the other measuring 1.5 cm. Those dimensions represented only part of the lesions because of the fact the slide itself is only 2 cm wide. After discussing the manner in which those lesions would appear on X-ray, Dr. Green concluded they would both appear even larger on X-ray.

The employer's five pathologists, Drs. Bush, Hutchins, Harnsbarger, Naeye and Kleinerman, did not diagnose complicated CWP. Dr. Naeye reported he found no large CWP opacities in the miner's lungs. He opined the lesions, in excess of one centimeter, here were due to a combination of coal dust exposure, cancer and radiation and that an X-ray film can give the impression of a much larger opacity than one found in pathology because lesions are often superimposed. Thus, while Dr. Naeye found lesions, he did not explicitly make an "equivalency" determination. Dr. Bush criticized Drs. Perper and Green for not considering the composition of the lesions which were "exaggerated" in size by the growth of the carcinoma with associated fibrosis stonma, but not complicated CWP. He believes only the CWP portion of a lesion may be used to address the severity of the disease. He did not see the 2.3 cm by 2.3 cm lesion identified by Dr. Perper in the slides. Dr. Hutchins, agreeing with Drs. Naeye and Bush, found no large opacities of CWP existed in the miner's lungs. Likewise, Drs. Harnsberger and Kleinerman had earlier not found complicated CWP. However, the Board observed that Dr. Kleinerman had not made an equivalency determination.

The employer's pathologists, Drs. Naeye, Hutchins, and Bush, focused more on the question of whether the lesions met the medical definition of complicated pneumoconiosis. More specifically, unlike claimant's pathologists, they opined the composition of a lesion detected on pathology is determinative. That is, only the pneumoconiotic (or anthracotic) portion of such a lesion may be considered in making an equivalency determination. Drs. Perper and Green did not distinguish lesions based on their composition. The employer's pulmonary experts, Drs. Fino, Crisalli, and Stewart, who submitted supplemental reports, each explained that the new reports by Drs. Perper and Green did not change their prior opinions that the objective studies, pathology evidence and radiological evidence failed to establish the existence of complicated CWP. It should be noted that section 718.304 does not refer to the medical

[26] In large measure because of his position regarding the composition of lesions.

conditions of either PMF or complicated CWP. It rather establishes a "legal" standard. *See Blankenship, supra.*

In *Williams v. Ray Todd Coal Co*., BRB No. 04-0388 (Dec. 23, 2004)(Unpub.), the Board also rejected a contention that judges may not consider medical opinions and objective tests detecting no disabling impairment in determining whether a claimant has established invocation of the irrebuttable presumption, under Section 718.304 (total disability due to complicated pneumoconiosis). Other evidence may show that X-ray opacities may not be what they appear to be. *Scarbro*, 220 F.3d at 256. The Fourth Circuit has explained that because Section 921(c)(3) provides an irrebuttable presumption only if "a chronic disease of the lung" is established, the totality of the evidence must be considered. *Lester*, 993 F.2d at 1145-46

Other than as mentioned, neither the Regulations nor any case law I have found either directly or explicitly addresses the matter of the specific composition of the lesions and opacities referred to in section 718.304. Section 718.304 does require that either the one centimeter opacity or the "massive lesions" be "yielded" by a "chronic dust disease of the lung." It certainly would make little sense to apply the presumption of complicated CWP if the pathologist found a 2 cm cancerous lesion in a miner who did not suffer a "chronic dust disease of the lung" and made an equivalency determination. However, once a miner is shown to suffer a "chronic dust disease of the lung," the regulation does not then implicate the portion which must be pneumoconiotic or anthracotic, but only that the dust disease "yields" such a lesion or opacity. Clearly then, the opacity or lesion must contain some pneumoconiotic or anthracotic material or macule, but a specific amount, e.g., 1% or 50%, is not required. Here, the employer's pathologists do not say the dust disease did not "yield" the lesions or opacities. Thus, their argument fails.

The *Lester* decision, cited by the Board, in *Williams*, at least makes clear that "a chronic disease of the lung" "the type of which Congress was concerned", i.e., CWP, must exist. At least simple CWP has been established here. The prosector clearly found the nodules and lesions of complicated CWP, as well as other indicia of medical complicated CWP. However, the prosector did not explicitly discuss the microscopic composition of those specific lesions which he had measured on gross examination, nor did the claimant's pathologists. Although the employer's pathologists did discuss the composition of certain lesions, they did not explain either the process by which lesions of complicated CWP are generated or created or whether one may be diagnosed with complicated CWP when only a portion of a larger lesion is anthracotic or pneumoconiotic. From their conclusions, one might presume they believe that a lesion must consist of either solely anthracotic or pneumoconiotic material of a certain size or portion of the whole in order to justify a complicated CWP diagnosis. This is somewhat akin to the rejected argument concerning "non-qualifying" conglomerations of micronodules versus one large "qualifying" macronodule the employers have unsuccessfully used before.[27]

Thus, particularly given the background of simple CWP and the pathological findings of Drs. Dy and Klapproth and surgeon Kahn, as well as the round-about definition in the

[27] See, e.g., *Coutts v. Lion Mining Co*., BRB No. 04-0919 BLA (July 28, 2005).

regulations, I am not convinced the law requires the fine distinctions sought by the employer concerning the composition of lesions necessary to invoke the presumption.[28]

Despite the criticism of Dr. Perper's experiment, both he and Dr. Green both made the required "equivalency determination." The employer's pathologist's opinions concerning this matter are based upon a false premise, that is that the lesions must be comprised of solely anthracotic or pneumoconiotic material, and are thus discredited. They focus on the medical definitions rather than the legal definition.

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id*.; *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are board certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp*., 8 B.L.R. 1-211, 1-213 n. 5 (1985).

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. ' 718.102(b). Here, the overwhelming majority of the X-ray readings are positive.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R.§ 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co*., 6 BLR 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP,* 6 BLR 1-368 (1983).

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[28] The composition of lesions is discussed in detail in "Criteria for a Recommended Standard", Occupational Exposure to Respirable Coal Mine Dust, U.S. Department of Health & Human Services, Public Health Service Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health . . ., September 1995, sections 4.1.2.2 and 4.1.2.1.2. "The primary histopathological lesion of CWP is the coal macule. . . it differs in the amount and nature of dust, the quantity and disposition of fibrous tissue, and the presence of focal emphysema.

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 BLR 1-597 (1984). The qualifications of both the employer's and claimant's consulting doctors are somewhat similar. However, the decisive criterion in this case is the faulty premise relied on by the employer's experts.

The claimant has established pneumoconiosis pursuant to subsection 718.202(a)(2) by autopsy and biopsy evidence. The claimant has also established pneumoconiosis under § 718.202(a)(3). Legally defined complicated pneumoconiosis is established in this case.

I find the claimant has met her burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, the claimant must show that it arose, at least in part, out of coal mine employment. 20 C.F.R.§' 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, the claimant receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment.

D. Death due to Pneumoconiosis

Subsection 718.205(c) applies to survivor's claims filed on or after January 1, 1982 and provides that death will be due to pneumoconiosis if any of the following criteria are met:

> (1) competent medical evidence established that the miner's death was caused by pneumoconiosis; or
>
> (2) pneumoconiosis was a substantially contributing cause or factor leading to the miner's death or the death was caused by complications of pneumoconiosis; or
>
> (3) the presumption of § 718.304 [complicated pneumoconiosis] is applicable.

20 C.F.R.§' 718.205(c). Only criterion (3) is met. It is established the miner suffered from legal complicated pneumoconiosis.

The Board concludes that death must be "significantly" related to or aggravated by pneumoconiosis, while the circuit courts have developed the "hastening death" standard which

requires establishment of a lesser causal nexus between pneumoconiosis and the miner's death. *Foreman v. Peabody Coal Co*., 8 B.L.R. 1-371, 1-374 (1985). The regulation now provides that "[P]neumoconiosis is a 'substantially contributing' cause of death if it hastens the miner's death." 20 C.F.R. § 718.205(c)(5). The United States Court of Appeals for the Third Circuit has also held that any condition that hastens the miner's death is a substantially contributing cause of death for purposes of § 718.205. *Lukosevicz v. Director, OWCP,* 888 F.2d 1001, 1006 (3d Cir. 1989). [29]

Fifteen physicians provided opinions concerning the cause of death. All agreed that the miner's adenocarcinoma was the immediate cause of his death. Of those fifteen, only Drs. Ranavaya, Perper, and Green, opined that coal worker's pneumoconiosis played a substantial role.[30] Eleven of fifteen physicians giving opinions concerning the cause of death, Drs. Zaldivar, Crisalli, Fino, Chillag, Bush, Stewart, Hutchins, Harnbarger, Loudon, Naeye, and Kleinerman, found that even the diagnosed simple CWP played no role in the miner's death nor did it hasten his death in any manner. Likewise, of ten physicians who discussed whether or not the miner suffered from complicated CWP or Progressive Massive Fibrosis, only Drs. Ranavaya, Perper, Green, and Dy, the autopsy prosector diagnosed it.[31] Six physicians, Drs. Crisalli, Fino, Stewart, Harnsbarger, Naeye, and Kleinerman, found no PMF or complicated CWP. Only Drs. Ranavaya and Perper found that PMF or complicated CWP was a substantial contributing factor in the miner's death. Dr. Green implied it was. I give the most weight to the pathologists concerning the cause of death.

Survivors are not eligible for benefits where the miner's death was caused by a traumatic injury or the principal cause of death was a medical condition, i.e., cancer, not related to pneumoconiosis, unless the evidence establishes that pneumoconiosis was a substantially contributing cause of death. 20 C.F.R. § 718.205(c)(4); Neeley v. Director, OWCP, 11 B.L.R. 1 85 (1988) (survivor not entitled to benefits where the miner's death was due to a ruptured abdominal aortic aneurysm).

The Act and Regulations do not require that pneumoconiosis be the sole, primary or proximate cause of death, but rather that where the principal cause of the miner's death was not pneumoconiosis, that the evidence establish it was a "substantially contributing cause." 20 C.F.R. § 718.205(c)(4). *See, Lukosevicz v. Director, OWCP*, 888 F.2d 1001, 1005 (3rd Cir. 1989)(quoting 48 Fed. Reg. 24,276, 24,277(1), (n)(1983)).

An Administrative Law Judge may, in his discretion, accord greater weight to the medical opinion of the physician who performed the autopsy than to the opinions of those who reviewed the slides or findings. *Beckett v. Raven Smokeless Coal Co*., 14 B.L.R. 1-43, 1-46 (1990); *U.S. Steel Corp. v. Oravetz*, 686 F.2d 197 (3d Cir. 1982). However, before giving

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[29] The Fourth, Sixth, Seventh, Tenth and Eleventh Circuits have adopted this position in *Shuff v. Cedar Coal Co.*, 967 F.2d 977 (4th Cir. 1992), *cert. den.,*506 U.S. 1050, 113 S.Ct. 969 (1993); *Brown v. Rock Creek Mining Corp.*, 996 F.2d 812 (6th Cir. 1993)(J. Batchelder dissenting*);* and *Peabody Coal Co. v. Director, OWCP*, 972 F.2d 178 (7th Cir. 1992); *Northern Coal Co. v. Director, OWCP*, 100 F.3d 871 (10th Cir. 1996); *Bradberry v. Director, OWCP*, 117 F.3d 1361, 21 B.L.R. 2-166 (11th Cir. 1997).

[30] Dr. Ranavaya is board certified in occupational medicine.

[31] Drs. Kahn and Klapproth found it as a result of the 1990 lobectomy.

complete deference to the opinion of an autopsy prosector, an Administrative Law Judge must first determine the credibility and weight of any reviewing pathologist evidence and provide an adequate rationale for concluding that the autopsy prosector's first-hand examination of the body gave him an advantage over reviewing physicians under the particular facts of the case. *Urgolites v. Bethenergy Mines, Inc*., 17 B.L.R. 1-20 (1992). The Fourth Circuit Court of Appeals holds that mechanistic crediting of prosector's opinion solely on the basis the prosector viewed the miner's body is improper. *BethEnergy Mines Inc. v. Director, OWCP*, 92 F.3d 1176 (4th Cir. 1996) and *Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186 (4th Cir. 2000); *Hill v. Peabody Coal Co.,* Case No. 03-3321 (6th Cir. April 7, 2004)(Unpublished)(The Court reiterated its holding in *Eastover Mining Co. v. Director, OWCP* [*Williams*], 338 F.3d 501, (6th Cir. 2003), that treating physicians' opinions "get the deference they deserve based on their general power to persuade." Here, the prosector made several diagnoses, but did not specify the degree of contribution of CWP to the miner's death. Thus, I cannot give his conclusion much weight on cause of death.

Citing *Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 192 (4th Cir. 2000), the Sixth Circuit Court has held a doctor's conclusory statement on a death certificate, without further elaboration, is insufficient to meet claimant's burden as to the cause of death.[32] Here the death certificate, signed by Dr. Bae, lists COPD and CWP as a significant condition contributing to death. It is not shown that Dr. Bae has any specialized knowledge or relationship to the miner. Thus, I cannot give his conclusion much weight.

The lifetime AGS and PFS do not establish that the miner had a total respiratory disability as of 1993, three years before his death, despite the one "qualifying" post-bronchodilator result. This was after his 1990 lobectomy and conducted at a time when he was clearly suffering from extensive lung cancer. Given the above discussion and the fact that twelve of fifteen well-qualified physicians, both pathologists and pulmonologists, found CWP either played no role or no substantial role in the miner's death, I do not find it established that pneumoconiosis was a substantially contributing cause of death.

I find that the evidence fails to establish that pneumoconiosis was a substantially contributing cause of death. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113 (1988).

G. Attorney Fees

An application by claimant's attorney for approval of a fee has not been received. Thirty days is hereby allowed to claimant's counsel for the submission of such an application. Counsel's attention is directed to 20 C.F.R. § 725.365- 725.366. A service sheet showing that service has been made upon all the parties, including claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

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[32] *Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186, 22 B.L.R. 2-251, 2000 WL 665639 (4th Cir. May 22, 2000). Prosector's mere conclusion on death certificate that CWP contributed to miner's death was insufficient without further explanation to support such a finding under Act.

CONCLUSIONS

In conclusion, the claimant established that the miner had pneumoconiosis, as defined by the Act and Regulations at the time of his death. The pneumoconiosis arose out of his coal mine employment. Pneumoconiosis was not a substantially contributing cause or factor leading to the miner's death. The claimant has established the criteria of legal complicated CWP and thus is entitled to the presumption that his death was due to CWP. Therefore, the Claimant has established a mistake in determination of fact. The Claimant is therefore entitled to benefits.

ORDER

It is ordered that the claim for benefits under the Black Lung Benefits Act is hereby **GRANTED.**

It is further ordered that the employer, shall pay to the claimant all benefits to which she is entitled under the Act commencing June 1, 1996.[33]

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers= Compensation, OWCP, ESA, (ADCMWC@), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**.[34] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at

[33] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund (with interest) for the full amount of all such payments. 20 C.F.R. § 725.602(a).

[34] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001).
(d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.

the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

E-FOIA Notice: Under e-FOIA, final agency decisions are required to be made available via telecommunications, which under current technology is accomplished by posting on an agency web site. *See* 5 U.S.C. § 552(a)(2)(E). *See also* Privacy Act of 1974; Publication of Routine Uses, 67 Fed. Reg. 16815 (2002) (DOL/OALJ-2). Although 20 C.F.R. § 725.477(b) requires decisions to contain the names of the parties, it is the policy of the Department of Labor to avoid use of the Claimant's name in case-related documents that are posted to a Department of Labor web site. Thus, the final ALJ decision will be referenced by the Claimant's initials in the caption and only refer to the Claimant by the term "Claimant" in the body of the decision. If an appeal is taken to the Benefits Review Board, it will follow the same policy. This policy does not mean that the Claimant's name or the fact that the Claimant has a case pending before an ALJ is a secret.

APPENDIX

Exh. #	**Dates 1. X-ray 2. read**	**Physician**	**Qualific-ations**	**Qual-ity**	**Classif-ication**	**Interpretation or Impression**
DX 1	3/01/79 3/06/79	Subramanian			1/1	
DX 1	3/01/79 3/06/79	Cole	B		Neg.	
DX 2	2/26/84	KLD				Portable: no evid. Active infiltrates.
DX 2	9/13/84	Goodwin				Min. scattered fibrosis. Little change since 9/5/84 film.
DX 2	9/14/84	Goodwin				Portable: Sternotomy with CABG surgery.
DX 2	9/15/84	Goodwin				Portable
DX 2	9/16/84	Goodwin				Portable: min. Atelectasis.
DX 2	8/18/90 10/4/90	Gaziano	B	1	2/2, q/r, Cat. A	ca
DX 2	8/18/90 10/29/90	Gaziano	B	1	2/2, q/r, Cat. A	ca
DX 2	8/18/90 10/16/90	Cole	B; BCR	2	1/1, q/s,	Ca, co, hiu
DX 2	8/18/90 4/23/91	Wiot	B; BCR	2	2/1, q/t, Cat. A	
DX 2	8/18/90 4/26/91	Spitz	B; BCR	2	1/2, q/q, Cat. A	
DX 2	8/18/90 5/1/91	Shipley	B; BCR	1	1/2, q/s, Cat. B	Ca, co
DX 2	8/18/90 6/17/91	Wheeler	B; BCR	2	1/1, q/p,	ca
DX 2	8/18/90 6/17/91	Scott	B; BCR	1	1/0, p/q	ca
DX 2	8/18/90 9/19/90	Gaziano	B	1	1/1, Cat. A	ca

DX 2	10/25/90 10/25/90	Smith				Large mass lesion LUL suspicious for malignancy
DX 2	10/25/90 1/12/95	Wiot	B; BCR	2	2/1, q/t	ca
DX 2	10/27/90 10/27/90	Smith				No acute pulmonary infiltrates.
DX 2	10/28/90 1/12/95	Wiot	B; BCR	u/r		
DX 2	10/28/90 10/28/90	Wheatley				Normal heart.
DX 2	10/28/90 1/12/95	Wiot	B; BCR	u/r		
DX 2	10/29/90 10/29/90	Reifsteck				Infiltrate RLL w Atelectasis.
DX 2	10/29/90 1/12/95	Wiot	B; BCR	u/r		
DX 2	10/30/90 10/30/90	Cordell				Atelectasis LL.
DX 2	10/30/90 1/12/95	Wiot	B; BCR	u/r		Portable.
DX 2	10/31/90 10/31/90	Reifsteck				Patchy infiltrate LLL. Mild pulmonary edema.
DX 2	10/31/90 1/12/95	Wiot	B; BCR	2	2/1, q/t, O	od
DX 2	11/2/90 11/2/90	Reifsteck				No other def. signs of acute infiltrates.
DX 2	11/2/90 1/12/95	Wiot	B; BCR	2	2/1, q/t, O	od
DX 2	11/26/90	Hayes			CWP	
DX 2	2/25/91	Briley				Interstitial nodular pul. Fibrotic change.
DX 2	5/14/91 5/17/91	Leef		1	2/1, r/r	
DX 2	5/14/91 5/30/91	Gayler		1	1/1, q	
DX 2	5/14/91 5/30/91	Wheeler	B; BCR	1	2/2, q/q	
DX 2	5/14/91 5/30/91	Scott	B; BCR	1	1/2, q/r	
DX 2	5/14/91 12/14/91	Wiot	B; BCR	1	2/1, q/t	od

DX 2	5/14/91 12/19/91	Spitz	B; BCR	1	2/1, r/q	
DX 2	5/30/91	Dwyer			CWP	
DX 2	8/26/91	Briley			CWP	
DX 2	11/18/91	Hayes				Nodular fibrosis, appearance of CWP.
DX 2	3/10/92	Kayi			CWP	Advanced CWP.
DX 2	3/30/92	Hayes			CWP	
DX 2	7/27/92 7/27/92	Sexton				Nodular fib. Chges likely CWP.
DX 2	7/29/92 1/25/95	Wiot	B; BCR	1	2/1, q/t	px
DX 2	8/1/92	Briley				Interstitial nodular chges.
DX 2	8/1/92 1/12/95	Wiot	B; BCR	1	2/1, q/t	od
DX 2	8/6/92	Sexton				Nodular fib. Chges - CWP.
DX 2	11/9/92 11/9/92	Smith				Nod. Densities LUL, malignant etiology.
DX 2	2/2/93 1/12/95	Wiot	B; BCR	1	2/1, q/t	
DX 37	9/24/93 9/24/93	Conner				Rounded nodular densities lungs. Consistent with metastatic disease.
DX 2	9/24/93 1/12/95	Wiot	B; BCR	1	2/1, q/t	Ca, od
DX 2	4/19/94 4/19/94	McJunkin				Bilat. Pul. Nodules. Fib. Chges. No def. acute infiltrates.
DX 2	4/19/94 1/12/95	Wiot	B; BCR	1	2/1, q/t	Ca, od
DX 37	5/4/94 5/4/94	Tanguilig				Nodular densities both lungs.
DX 2	5/4/94 1/22/95	Wiot	B; BCR	1	2/1, q/t	Ca, od
DX 37	5/25/94 5/25/94	Skeens				Nod. c/I metastatic disease.
DX 2	5/25/94 3/6/95	Shipley	B; BCR		1/1, r/t	Ca, co
DX 2	5/25/94 3/13/95	Spitz	B; BCR		1/2, r/q	ca

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; R- Radiologist; BCP-Board-Certified Pulmonologist; BCI-Board-Certified Internal Medicine; BCCC- Board-Certified Critical Care. Readers who are board certified radiologists and/ or B readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.
In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Decided under Part 727 of the Regulations).